Third Party Intervention

COMMISSIONER FOR HUMAN RIGHTS
COMMISSAIRE AUX DROITS DE L'HOMME

COUNCIL OF EUROPE
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Third party intervention
by the Council of Europe Commissioner for Human Rights

under Article 36, paragraph 3, of the European Convention on Human Rights

Application No. 39468/17

Eugeniu CLIPEA and Virginia IAPARA
v. the Republic of Moldova

Strasbourg, 17 June 2021

CommDH(2021)19
English only

Introduction

1. On 9 April 2021, the Council of Europe Commissioner for Human Rights (hereinafter: 'the Commissioner') informed the European Court of Human Rights (hereinafter: 'the Court') of her decision to intervene as a third party in the Court's proceedings, in accordance with Article 36, paragraph 3, of the European Convention on Human Rights (hereinafter: 'the Convention'), and to submit written observations concerning the case of *Eugeniu CLIPEA and Virginia IAPARA v. the Republic of Moldova* (application no. 39468/17). This case concerns the alleged ill-treatment of persons with psychosocial disabilities at a psychiatric hospital. The applicants allege that their treatment in the hospital and the dismissal of their complaints by the prosecution violated their rights under Articles 3 (prohibition of torture) and 8 (right to respect for private and family life) of the Convention, including in conjunction with Article 14 (non-discrimination).

2. According to her mandate, the Commissioner promotes the effective observance of human rights; assists member states in the implementation of Council of Europe human rights instruments, particularly the Convention; identifies possible shortcomings in laws and practices concerning human rights; and provides advice and information regarding the protection of human rights across the region.[1]

3. The protection of the human rights of persons with disabilities has long been a priority issue for the Commissioner's Office and has been addressed extensively in the framework of both country monitoring and thematic work. When it comes to persons with psychosocial disabilities (i.e. disabilities arising from the interaction between a person with mental health problems and their environment), successive Commissioners have consistently pointed to institutionalisation and coercion in mental health services as a persistent source of human rights violations and urged member states to eliminate these practices in favour of community-based mental health services based on consent. The Commissioner considers that the present case raises issues of a general nature regarding the impact on the enjoyment of human rights of the use of coercion in psychiatry, as well as of reliance on an institution-based mental health system characterised by services concentrated in large psychiatric hospitals.

4. This intervention is based on country monitoring conducted on these issues by the Commissioner's Office in many country visits, including a report published in 2020 following a visit to the Republic of Moldova.[2] It also builds on thematic work carried out by the Commissioner's Office over the years.

5. Section I of the present written submission gives an overview of the rapid evolution in recent years of the approach to coercion and institution-based mental health services at the international and European levels. Section II summarises the thematic and country work conducted on this issue by the Commissioner's Office, including in the Republic of Moldova. Section III contains the Commissioner's observations regarding the implications of these considerations for the human rights of persons with psychosocial disabilities which are protected under the Convention. It is followed by the Commissioner's conclusions.

I. The Evolution of the approach towards mental health services at the international and European levels

The impact of the United Nations Convention on the Rights of Persons with Disabilities

6. The Commissioner observes that the attitude towards mental health is undergoing a profound paradigm shift at the international level. Long-standing legal traditions taking coercion for granted in psychiatry, including involuntary placement and treatment, and an institution-centric approach, are increasingly being challenged. This is accompanied by a shift from a primarily biomedical approach reducing mental health problems to "mental disorders", towards a rights-based, psychosocial understanding of mental health. The main catalyst of this evolution has been the entry

[1] Resolution (99)50 on the Council of Europe Commissioner for Human Rights, adopted by the Committee of Ministers on 7 May 1999.
[2] Report by Dunja Mijatović, Commissioner for Human Rights, following her visit to the Republic of Moldova from 9 to 13 March 2020, CommDH(2020)10, 25 June 2020.

into force in 2008 of the United Nations Convention on the Rights of Persons with Disabilities (hereinafter: "the CRPD").

7. In her work regarding the rights of persons with disabilities, including psychosocial disabilities, the Commissioner consistently refers to the UN CRPD as the international benchmark and legal reference point in all matters pertaining to disability. This instrument, the first universal human rights treaty of the 21st century, is the most advanced document protecting the rights of persons with disabilities, in large part thanks to the involvement of the representative organisations of persons with disabilities in its elaboration, and it represents the culmination of decades of advocacy by persons with disabilities. This convention embodies the paradigm shift in attitudes and approaches to persons with disabilities, without which their rights cannot be effectively protected. It requires a move from the medical model to the social model of disability which entails, among others, viewing persons with disabilities as active subjects with equal rights, capable of taking their own decisions and contributing to societies rather than as objects of charity and medical treatment. Despite its relatively recent opening for signature, this Convention has been ratified by 46 of the 47 member states of the Council of Europe, and the European Union is also a party to it.

8. Of particular relevance to allegations of ill-treatment and the use of coercion in mental health settings are Article 12 of the CRPD on equal recognition before the law, Article 13 on access to justice, Article 14 on the prohibition of discrimination against persons with disabilities regarding the right to liberty and security of person, Article 15 on freedom from torture, inhuman or degrading treatment, Article 16 on freedom from exploitation, violence and abuse, Article 17 on the right to physical and mental integrity, Article 19 on the right to live independently and to be included in the community, and Article 25 on the right to the highest attainable standard of heath on the basis of free and informed consent.

9. The treaty body established by the CRPD, the Committee on the Rights of Persons with Disabilities, has a categorical approach as regards what these undertakings entail in terms of coercive practices in psychiatry. In its first general comment on Article 12 of the CRPD, the Committee affirmed the following position:

> "As has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention. States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; must ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available; and must provide access to independent support. States parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned."[3]

10. This approach has been maintained consistently throughout the Committee's concluding observations regarding individual member states, as well as in the framework of the individual complaints procedure set up under the Optional Protocol of the CRPD. It recognises no exception from the absolute ban on forced treatment, including on grounds such as "risk of harm to oneself" or "danger to others".

11. In connection with the present case, the Commissioner notes that, in its concluding observations regarding the Republic of Moldova, the Committee found in 2017 that the legislation on mental health in place (Law No. 1402) was not in line with the CRPD, as it allowed "the forced internment in a psychiatric establishment and non-consensual psychiatric treatment of persons with disabilities,

[3] UN Committee on the Rights of Persons with Disabilities, General comment No. 1 on Article 12 of the UN CRPD, CRPD/C/GC/1, 19 May 2014.

on the grounds of psychosocial and/or intellectual impairment". It also expressed concern about "the inhuman and degrading treatment of persons with disabilities in institutions perpetrated by staff members, caregivers or other residents, including acts of neglect and the use of chemical and physical restraints, solitary confinement and forced medication as punishment. It is also concerned about the inefficiency and inadequacy of complaints systems, delays in investigations and lack of monitoring of institutions".[4]

Developments in other international bodies and the Council of Europe

12. Other key actors at the UN level endorse and support the same approach as the Committee on the Rights of Persons with Disabilities, including the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the rights to physical and mental health. On many occasions, these experts stressed that "forced admission to medical institutions and coercive treatments in institutions will bring harmful effects such as pain, trauma, humiliation, shame, stigmatisation and fear to people with psychosocial disabilities".[5]

13. Regarding the question as to whether forced treatment can amount to torture or inhuman or degrading treatment, in a report presented in 2020, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment stated that: "it must be stressed that purportedly benevolent purposes cannot, *per se*, vindicate coercive or discriminatory measures. For example, practices such as involuntary […] psychiatric intervention based on "medical necessity" of the "best interests" of the patient, generally involve highly discriminatory and coercive attempts at controlling or "correcting" the victim's personality, behaviour or choices and almost always inflict severe pain or suffering. In the view of the Special Rapporteur, therefore, if all other defining elements are given, such practices may well amount to torture".[6]

14. The Commissioner observes that this profound paradigm shift is increasingly being followed by the key organisations of relevance to the medical profession. On 10 June 2021, the World Health Organisation launched new guidance in which it acknowledges the need to address discrimination and promote human rights in mental health care settings, which "includes eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion and tackling the power imbalances that exist between health staff and people using the services".[7] The fact that the World Health Organisation itself has taken such a clear position in favour of eliminating coercion in mental health settings undermines the assumption that involuntary measures could be permissible as a therapeutic necessity. The Commissioner also notes that the World Psychiatric Association issued a position statement on the need to reduce coercion in October 2020.[8]

15. A significant development signalling the beginnings of a similar shift within the Council of Europe was the unanimous adoption in 2019 of a Resolution by the Parliamentary Assembly of the Council of Europe, which calls on member states to end coercion in mental health.[9] Pointing to the fact that the number of persons subjected to coercion was still growing in Europe, the lack of scientific evidence supporting the purported benefits of coercion in mental health settings and the ineffectiveness of so-called "safeguards" to prevent excessive use of coercion, the Parliamentary Assembly urged member states to immediately start the necessary transition for the abolition of coercive practices in mental health settings, *inter alia,* by developing road maps to radically reduce coercive practices as a first step, while developing non-coercive, effective and accessible support services for people experiencing crises and emotional distress, and to combat the stigmatisation of persons with psychosocial disabilities.

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[4] Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of the Republic of Moldova, CRPD/C/MDA/CO/1, 18 May 2017.

[5] "UN Rights experts call on Council of Europe to stop legislation for coercive mental health measures", press release of 28 May 2021.

[6] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment of punishment to the UN Human Rights Council, A/HRC/43/49, 14 February 2020.

[7] World Health Organisation guidance and technical packages on community mental health services, Main Guidance, p. xviii.

[8] "Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care", position statement by the World Psychiatric Association, October 2020.

[9] Parliamentary Assembly of the Council of Europe, Resolution 2291 (2019), "Ending coercion in mental health: the need for a human rights-based approach", adopted on 26 June 2019.

II. Overview of the Commissioner's work on mental health

16. The Commissioner, like her predecessors, has consistently advocated for mental health reform, including the urgent need to deinstitutionalise mental health services and to eliminate coercive practices in mental health settings (in these settings, coercive practices may include for example, involuntary admission, involuntary treatment, the use of seclusion and of physical, mechanical, or chemical restraint). In the Commissioner's view, this is not only a legal necessity in order to bring the legislation of member states in line with CRPD standards, but also the only viable way of durably reducing the numerous human rights violations that the Commissioner continues to observe around Europe. Persons with psychosocial disabilities routinely suffer some of the most egregious human rights violations on our continent, including violations of Article 3 and Article 8 of the Convention, in particular as a direct result of mental health services themselves displaying a tendency towards paternalism, coercion and institutionalisation.

17. The worst forms of these violations occur in institutional settings, such as closed psychiatric hospitals, as numerous reports by the European Committee for the Prevention of Torture (CPT),[10] the Commissioner's Office, and national preventive mechanisms attest. In the Commissioner's experience, such institutions are almost invariably breeding grounds for human rights violations, including inhuman or degrading treatment in the sense of Article 3, for several reasons. In particular, by isolating their patients from the community and the support networks every person relies on in their lives, such institutions not only jeopardise long-term recovery, but they also make human rights violations at the hands of staff or other patients easier to commit with impunity and harder to prove. In combination with the generally dismissive and discriminatory attitude of most prosecutors and courts vis-à-vis persons with psychosocial disabilities, this explains the clear gap between widespread human rights violations documented in visits to such institutions by specialised bodies on the one hand and the very small number of cases that are actually adjudicated by courts throughout Europe, on the other.

18. The Commissioner summarised her position on the need for mental health reform and the elimination of coercion in a recent Human Rights Comment published on 7 April 2021.[11] This position must be seen against the background of the growing consensus within the international community to consider involuntary measures without the informed consent of persons with mental health problems as human rights violations, or even as possibly amounting to torture, as described in the previous section. In this connection, the Commissioner acknowledges the impact of the paradigm shift of the CRPD, as well as the efforts of civil society, in particular of persons with lived experience of mental health problems and psychosocial disabilities, to have their say in policy-making.

19. The Commissioner's position is based on her work and personal observations in many member states, as well as her thematic work on the human rights of persons with disabilities. One of these observations concerns the marked differences in the level of involuntary placements between countries, but also between different regions of the same country or even from one hospital to another, suggesting that the main cause of coercion is not the inherent dangerousness of persons or therapeutic necessity, but an institutional culture that confines more out of prejudice or habit. The existing scientific research also supports this interpretation.[12]

20. Based on her country work, the Commissioner has stressed on numerous occasions the vicious circle caused by a mental health approach based on institutionalisation and coercion, which perpetuates the isolation of the persons who need the support of their community the most, fuelling more stigma and irrational fear concerning the perceived dangerousness of persons with psychosocial disabilities. The lack of community-based, voluntary mental health services also results in even more coercion and deprivation of liberty.

21. The Commissioner also observed on many occasions that safeguards supposed to protect persons from arbitrariness and ill-treatment are generally reduced to mere formalities because they operate in a legal system where persons with mental health problems do not even have a chance to have

[10] Report to the Bulgarian Government on the visit to Bulgaria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 10 to 21 August 2020, CPT/Inf (2020) 39.
[11] Human Rights Comment by the Commissioner for Human Rights, "Reform of mental health services: an urgent need and a human rights imperative", 7 April 2021.
[12] For example, Morandi, Silva, *et al.*, Mental health professionals' feelings and attitudes towards coercion, International Journal of Law and Psychiatry, Volume 74, January–February 2021.

their voices heard, owing to the profound power asymmetry between the patient and physician in most mental health systems. Judges almost invariably follow the opinion of the psychiatrist over the wishes of the patient when the law provides for such a possibility. Therefore, the analysis of the legislative framework alone, without the general context of the prevailing legal practice in the country concerned, is a very poor indication of whether persons with psychosocial disabilities are actually protected from violence and abuse. It is another common occurrence that what is defined as "last resort" in mental health legislation often becomes the default approach, due to institutional habits, lack of adequately trained staff or even as a matter of convenience. The mere existence of legislation legitimising coercion not only perpetuates the stigma around mental health, but it discourages persons from seeking help at an early stage of their mental illness for fear of being forcibly treated, thus allowing their condition to progress to crisis levels in many cases and increasing the risk of recourse to involuntary measures.

22. The Commissioner also observed on numerous occasions that even patients who voluntarily place themselves in mental health care frequently lose control over their treatment choices once they enter the system, with an institutional and coercive logic taking over, for example by being confined to certain spaces or being forcibly medicated by staff. Patients in such situations have often no means of challenging these practices.

23. In the opinion of the Commissioner, institutionalisation and coercion in mental health services is almost invariably the result of the lack of community-based, preventive and recovery-oriented alternatives. Many examples around Europe and beyond show that it is possible to avoid institutionalisation and coercion altogether, including for persons facing severe mental health problems such as psychosis, through the use of alternatives such as support provided by peers or a support network, patient advocates/personal ombudspersons, advanced planning, community crisis resolution or open dialogue, as well as integrating mental health care into primary healthcare.

24. Member states which decided to de-institutionalise their mental health services, such as Italy in the 1970s, have proven that it is possible to shift the vast majority of patients to community- and consent-based alternatives, while at the same time drastically reducing recourse to involuntary placement and treatment – today Italy has levels of involuntary placement which are 10 to 20 times lower than its neighbouring countries.[13] The Commissioner has also come across many examples whereby psychiatric hospitals progressively eliminated coercive measures, such as the use of restraints, simply by retraining staff on conflict management and increasing physical activity for residents, without augmenting recourse to medication or having to change legislation.[14]

25. Finally, the Commissioner would like to stress that experts point to a glaring absence of evidence to substantiate the supposed benefits of forced treatment, whereas there is ample evidence that coercion in psychiatric settings may lead to substantial trauma and that, as indicated above, the risk of coercion actually deters persons experiencing mental ill-health from seeking help.[15]

26. In a report published on 25 June 2020 following her visit to the Republic of Moldova in March 2020,[16] the Commissioner observed that mental health care was still largely institution-based in the country, with care provided within three psychiatric hospitals and residential institutions (referred to as internats), functioning as long-term care facilities for people with mental illness. While the government had introduced certain reforms and pilot projects, a study assessing the reforms implemented between 2007 and 2017 found that mental health care remained largely institutionalised with few alternative care options in the community.[17] The Commissioner noted that the government had adopted a National Programme for de-institutionalisation of persons with intellectual and psychosocial disabilities in 2018.

27. In her recommendations to the Moldovan authorities, the Commissioner urged them to undertake more ambitious reforms of the mental health policy, with a view to drastically reducing and progressively eliminating recourse to coercive practices in psychiatry.

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[13] Rains, Zenina, *et al.*, "Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study", The Lancet Psychiatry, Volume 6, Issue 5, 1 May 2019.
[14] See, for example, the news article on the elimination of recourse to restraints at the psychiatric centre in Bellerup in Denmark, DR, 27 January 2017.
[15] Sugiura, Mahomed, *et al.*, "An end to coercion: rights and decision-making in mental health care", Bulletin of the World Health Organisation, 1 January 2020.
[16] CommDH(2020)10, *op. cit.*
[17] de Vetten-Mc Mahon, Shields-Zeeman, Petrea, *et al.*, "Assessing the need for a mental health services reform in Moldova: a situation analysis", International Journal of Mental Health Systems, 45 (2019), 20 June 2019.

III. General observations on the protection of the human rights of persons with psychosocial disabilities under the Convention

28. In the light of these considerations, the Commissioner considers that the traditional understanding according to which forced treatment and coercion are inevitable as a "last resort" option, provided that there are a number of legal safeguards surrounding these measures, is no longer tenable. The Commissioner acknowledges that this traditional understanding, as the dominant paradigm prevalent until the 21st century, underpins the European Convention on Human Rights and several other Council of Europe standards, as well as the legislation of most Council of Europe member states, despite the fact that reform processes are in progress in many. One reason for this is the fact that the global paradigm shift regarding institutionalisation and coercion in psychiatry, currently occurring in the UN system and the Council of Europe as described in Section I, is very recent and challenges centuries-old legal traditions.

29. In the Commissioner's opinion, the lack of alignment between mental health legislations in member states and their CRPD obligations must be put in context. The lack of priority given to the necessary reforms can be explained by several factors. One of these is the clear disconnect between the systemic nature and the severity of human rights violations which routinely occur in psychiatric hospitals, and the relatively few cases that are eventually brought to the attention of national courts or the European Court of Human Rights, the reasons for which were addressed in the previous section. As an exceptionally marginalised group, persons with psychosocial disabilities are severely disadvantaged as regards access to justice. They rarely have the opportunity to draw attention to the severe human rights abuses they suffer, owing to many factors such as deprivation of legal capacity, lack of adequate decision-making support, legal aid and financial resources. The Commissioner's predecessors had already drawn the attention of the Court to the significant discrepancy between the vast scale of human rights violations suffered by persons with intellectual and psychosocial disabilities and the relatively low number of court cases tackling these violations,[18] a situation contributing to the extreme vulnerability of this group and requiring special attention, including as recognised in the case-law of the Court for decades.[19]

30. Persons with psychosocial disabilities also face extreme prejudice, stigma and discrimination in administrative and legal proceedings, including from investigating authorities and courts. In addition, involuntary placement and treatment, such as forced medication, not only cuts persons with psychosocial disabilities off from society and ordinary support networks that citizens rely on to enforce their human rights, it can also alter mental states and directly affect their ability to do so.

31. As per the Court's established case-law considering the Convention as a living instrument, "the Court can and must take into account elements of international law other than the Convention". The consensus emerging from specialised legal instruments, such as the UN CRPD, which has been ratified by all Council of Europe member states but one, is crucial in this respect by showing in a precise area that there is common ground in modern societies.[20]

32. While the Convention provides for a mental health exception under Article 5, in the opinion of the Commissioner the evolution of the international consensus has reached such a level as to warrant a less tolerant approach to institution-based mental health systems and coercion when viewed from the angles of Articles 3 and 8. The Commissioner considers that a reading of these Articles that takes account of this fundamental evolution is not only feasible in accordance with the Court's well established case-law of considering the Convention as a living instrument, but that it is also desirable in order to avoid a widening gap between the protections afforded to persons with psychosocial disabilities under the Convention system and other international standards, most notably the UN CRPD as the universal *lex specialis* in all matters pertaining to the rights of persons with disabilities. The following includes the Commissioner's reflections on aspects of the Court's existing case-law that could be instrumental in supporting this process.

33. A vital element in the implementation of the human rights of persons with disabilities is the concept of reasonable accommodation, defined in the CRPD as the necessary adjustments and means required to ensure that persons with disabilities can enjoy their rights on an equal footing with others,

[18] Third party intervention by the Council of Europe Commissioner for Human Rights in the case *the Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania*, CommDH(2011)37, 14 October 2011.
[19] *Keenan v. the United Kingdom*, App. No. 27229/95, judgment of 3 April 2001, para. 111; *Bureš v. the Czech Republic*, App. No. 37679/08, para. 85.
[20] *Bayatyan v. Armenia*, App. No. 23459/03, judgment of 7 July 2011, para. 102; *Demir and Baykara v. Turkey,* App. No. 34503/97, judgment of 12 November 2008, para. 86.

while not imposing a disproportionate or undue burden. In the opinion of the Commissioner, the right to reasonable accommodation must extend to the ability of persons with psychosocial disabilities to enforce their Convention rights, including their ability to exhaust domestic remedies before domestic courts and prove these human rights violations before the Court itself.

Considerations concerning positive obligations under Article 3 of the Convention

34. When applied to the positive obligations of member states under Article 3 to investigate allegations of human rights violations, reasonable accommodation could include, for example, waiving any restrictions linked to legal capacity that would otherwise stop persons with psychosocial disabilities from bringing these allegations, allowing disability rights NGOs to bring such claims on behalf of others, and ensuring that persons with psychosocial disabilities have access to all necessary decision-making support (as opposed to substituted decision-making). In the opinion of the Commissioner, allegations of ill-treatment in a closed psychiatric institution, in particular in the presence of cases of ill-treatment documented by national preventive mechanisms, international bodies, and other credible sources, should always establish a plausible suspicion and arguable complaint in accordance with the Court's case-law.[21]

35. Similar adjustments should be extended to judicial actions, including by waving court fees and delivering legal aid in an appropriate manner adapted to the needs of persons with psychosocial disabilities. When assessing the effectiveness of judicial proceedings, power asymmetries between patients and hospital staff which might be reflected in the investigations deserve special attention, for example when the authorities appear to have given more weight to the statements of medical staff over those of persons with psychosocial disabilities without justification, in particular when the latter were not allowed to speak on their own behalf. In the opinion of the Commissioner, the lack of decision-making support provided to persons with disabilities and of reasonable accommodation in proceedings would in itself cast serious doubts on their effectiveness.

36. In the Commissioner's view, given the often insurmountable barriers people with psychosocial disabilities face in accessing justice, the Court's case-law regarding the easing of standing requirements in the case of *Campeanu v. Romania*[22] could also be potentially relevant in providing reasonable accommodation to those who bring forward allegations of ill-treatment in psychiatric institutions.

Considerations regarding substantive aspects of Article 3 of the Convention

37. The Commissioner considers that the use of coercion in psychiatry, including for example the use of mechanical or chemical restraints, confinement, isolation and forced medication, should always be considered to reach the minimum level of severity to fall within the scope of Article 3, considering the severe fear, anguish, feelings of helplessness, loss of dignity and other mental suffering they invariably cause, as explained under Section II of the present submission.

38. Regarding the burden of proof necessary to support allegations of ill-treatment in closed psychiatric institutions, the Commissioner considers that the existence of reports of systemic human rights violations in psychiatric institutions from credible sources, such as disability rights NGOs, national preventive mechanisms and international bodies, could create a strong presumption in favour of the applicants and a corresponding shift of the burden of proof.

39. In the previous sections, the Commissioner provided a summary of the legal developments linked to the entry into force of the CRPD, as well as the evolution of the medical and scientific understanding of mental illness in recent years. In the Commissioner's view, these developments justify a critical review of the approach that considers that medical interventions against a person's will cannot be regarded as inhuman or degrading if they are of therapeutic necessity from the point of view of established principles of medicine.[23] The Commissioner notes that in such cases, the Court also ascertains that procedural guarantees exist and have been complied with, including the use of such measures as a last resort.

40. The Commissioner considers that the evolving medical understanding casts serious doubts on whether coercive practices in psychiatry could be considered as a therapeutic necessity under any

[21] *Indelicato v. Italy*, App. No. 31143/96, judgment of 18 October 2001.
[22] *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania*, App. No. 47848/08, Grand Chamber judgment of 17 July 2014.
[23] *Herczegfalvy v. Austria*, App. No. 10533/83, judgment of 24 September 1992.

circumstance, as it transpires from the very recent guidance of the World Health Organisation on the matter.[24] This is all the more so if coercion took place in an institutional setting such as a closed psychiatric hospital.

41. As a minimum, the Commissioner considers that the availability to the applicants at the time of the facts of recovery-oriented, community and consent-based alternatives involving psychosocial interventions is a circumstance that should be taken into account. When the responding state fails to credibly demonstrate the existence of such alternatives, and in particular their availability in practice, the Commissioner considers that the involuntary measures in question cannot be considered to have been employed as a last resort and as a matter of therapeutic necessity, regardless of the severity of mental health problems which have been used to justify coercion. The Commissioner recalls, in this connection, that the mental health system of the Republic of Moldova at the time was (and still is) heavily institution-based, with no or few community-based or preventive alternatives being made available to persons with psychosocial disabilities in practice. As regards alternatives to coercive practices inside psychiatric hospitals, she would also like to point to the consistent findings of the CPT that psychiatric hospitals in the Republic of Moldova mainly relied on pharmacological treatments and that, for the vast majority of patients, there were no structured psycho-social rehabilitative activities, chiefly due to the non-existence of qualified staff.[25]

42. The Commissioner also considers that the existence of procedural safeguards should not be taken at face value, as their application is almost always highly formalistic, owing to the inherent power asymmetries between patients and medical staff within the legal systems of all member states. The Commissioner considers that contextual considerations, such as the success rate of patients in challenging coercive practices before courts in the country, provide useful indications as to the actual functioning of such safeguards.

Considerations regarding Article 8 of the Convention

43. The Commissioner considers that coercion in psychiatry, especially when it involves confinement in a psychiatric hospital, constitutes a very serious infringement of the right to private and family life as established in the Court's case-law, in particular when it comes to the right of physical and moral integrity of persons and their right to have relationships with other human beings and their community. An institution-based mental health system automatically separates persons from their support networks, such as families, friends, peers and neighbours, and removes any meaningful control over their most crucial life choices. Placement or other involuntary confinement in such institutions (including, for example, physical limitations on coming and going, cutting contacts with the outside world, isolation, seclusion or restraint) can thus amount to not only a violation, but an absolute negation of the right enshrined in Article 8 of the Convention.

44. In the light of the letter and spirit of the CRPD, and in particular its Article 19 on the right to live independently and to be included in the community, as well as the growing international consensus that institutions represent a serious violation of the human rights of persons with disabilities, the Commissioner finds it hard to reconcile non-community based mental health services with Article 8 requirements, notably that interferences with this right must be necessary in a democratic society.

45. In particular, the Commissioner considers that the failure by a member state to provide community-based alternatives to persons with psychosocial disabilities, to adopt de-institutionalisation plans and to carry them out in practice, are strong indicators of a systemic violation of Article 8.

Need for general measures

46. In the opinion of the Commissioner, the systemic nature of human rights violations caused by coercion-based mental health services, in particular when they are also institution-based, requires far-reaching general measures to be adopted by member states to rectify the source of these violations. The rarity of such cases reaching the Court, in stark contrast to the prevalence and frequency of these violations observed by the Commissioner, also points to a clear need for this type of measures in cases relating to mental health services.

47. Such general measures could include, *inter alia*, the obligation to adopt de-institutionalisation plans, establish moratoria against new placements in institutions of persons with disabilities, the

[24] World Health Organisation guidance and technical packages on community mental health services, *op. cit.*
[25] Report to the Government of the Republic of Moldova on the visit to the Republic of Moldova carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 28 January to 7 February 2020, CPT/Inf (2020) 27, p. 7.

establishment of community-based, recovery-oriented mental health services based on the clear and informed consent of all persons, for example by using the relevant guidance of the World Health Organisation, shifting of financial resources from institutions to such alternatives, and reforming legal capacity legislation to eliminate substituted decision-making, as well as establishing efficient monitoring of mental health services with the active involvement of disability rights organisations, and in particular of persons with lived experience of mental health problems.

IV. Conclusions

48. In conclusion, the Commissioner is of the opinion that:

- A reading of Articles 3 and 8 that reflects the fundamental shift in attitudes towards mental health globally appears necessary in order to avoid a widening gap between the protections afforded to persons with psychosocial disabilities under the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities. Such an evolution would be fully in accordance with the Court's established case-law;
- Regarding the positive obligations of states under Article 3, investigating authorities and courts should be expected to make a number of reasonable accommodations for persons with psychosocial disabilities, considering the reality that human rights violations in closed psychiatric institutions continue to occur widely, frequently and with impunity throughout Europe;
- Forced treatments in closed institutions always reach the minimum level of severity to fall within the scope of Article 3. The power asymmetry between the patient and other actors in the mental health system warrants a redistribution of the burden of proof concerning allegations of ill-treatment in connection with forced treatment, in particular in the presence of credible reports of human rights violations in mental health settings;
- The evolution in the medical field casts serious doubts on the assumption that coercive practices in psychiatry can be of therapeutic necessity, even as a last resort. As a minimum, involuntary measures should not be considered either as having been employed as a last resort or as being of therapeutic necessity if no community-based, recovery-oriented, psychosocial interventions based on consent were available as an alternative, both in law and in practice, in the state concerned;
- The existence of legal safeguards and a formalistic compliance with them cannot be considered as sufficient guarantees against human rights violations, when persons with psychosocial disabilities have no realistic prospects in practice to challenge decisions concerning involuntary treatment, owing to entrenched institutional discrimination;
- Placement or confinement in a psychiatric institution should always be considered a very serious infringement with the right enshrined under Article 8. The lack of community-based mental health services and persistent delays in de-institutionalisation are strong indicators of a systemic violation of this Article;
- The widespread and systemic nature of human rights violations caused by coercion-based mental health services requires a wide array of general measures in accordance with the legal and medical paradigm shift that is currently in progress around the globe.